

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

MARK SNOOKAL, an individual,)	
)	
)	
Plaintiff,)	
vs.)	Case No.
)	2:23-cv-6302-HDV-AJR
)	
CHEVRON USA, INC., a California)	
Corporation, and DOES 1 through)	
10, inclusive,)	
)	
Defendants.)	

REPORTER'S TRANSCRIPT

VIDEOTAPED DEPOSITION OF

DR. VICTOR ADEYEYE

VOLUME 2

Tuesday, April 22, 2025

Via Zoom Video Conferencing

6:00 a.m.

Reported by: Rachel N. Barkume, CSR, RMR, CRR
Certificate No. 13657

Dr. Victor Adeyeye

April 22, 2025

A P P E A R A N C E S

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THE VIDEOGRAPHER:

Cliff Gonshery

ALSO PRESENT:

Eguono Erhun, Chevron Nigeria Limited

Dr. Victor Adeyeye

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1 why maybe, maybe not. Alleviating the symptoms
2 medically does not equate to addressing the dissection,
3 the tearing. That's what I mean by that.

4 BY MS. FLECHSIG:

5 Q. What can you do to alleviate the symptoms of
6 the dissection?

7 A. Give some peripheral beta blockers.

8 Q. And what does that do for someone?

9 A. What's that?

10 Q. Yeah. What does that do for someone who's had
11 a dissection?

12 A. That would reduce the symptoms of pain,
13 excruciating pain, that individual would be having.

14 Q. Okay. Does it -- does it slow their risk of
15 death from occurring while they await surgery?

16 Or does it have any other benefits?

17 A. No. No. It confers no benefit of survival on
18 such individual.

19 Q. Understood. Okay.

20 Have you ever treated a patient whose dilated
21 aortic root has dissected?

22 A. None of note.

23 Q. Okay. Sorry, you said "none of note."

24 There's -- there's none that you have
25 treated?

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1 A. No. No. None.

2 Q. Okay. Have you ever treated someone with a
3 dilated aortic root that ruptured?

4 A. No.

5 Q. Okay. Okay. I want to ask about Mark Snookal,
6 the plaintiff in this lawsuit.

7 Have you reviewed the complaint in this
8 lawsuit?

9 A. How?

10 Q. Just -- yeah, have you reviewed the actual
11 complaint of the lawsuit, so at any time --

12 A. I'm not -- I'm not privy to that document.

13 Q. Okay. When did you first hear the name Mark
14 Snookal?

15 A. 2019.

16 Q. Okay. And how did you -- how did you hear
17 about him?

18 A. Via e-mail communication between myself and the
19 occupational health unit; Dr. Femi Pitan, you mentioned,
20 Dr. Asekomeh, Dr. Henry Aiwuyo.

21 Q. I'm sorry. Who was the third one that you
22 said?

23 A. Via e-mail communication --

24 Q. Oh --

25 A. -- with myself and the occupational health

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1 So if I'm to rephrase it, "How often do they
2 ask me for cardiac-related issue," depends on what they
3 have. I can't put a number or a frequency to how often
4 they confer me for cardiac-related issue.

5 Please note, the patient medevac, one patient I
6 mentioned to you, came from their site of the company
7 from the field to the onshore Warri Hospital. Thank
8 you.

9 BY MS. FLECHSIG:

10 Q. Okay. What's your best estimate of how often
11 you consult with them on a cardiac medical issue?

12 A. I would say two per month when there are gray
13 areas around there during their screening processes.

14 Q. Okay. So, in other words, when they're
15 screening someone for fitness for duty for a location
16 near you in -- in Warri or around there?

17 A. Thank you. Yeah.

18 Q. Okay. Have you ever spoken with Mark Snookal?

19 A. No. Mark Snookal is not my patient. I had no
20 medical consultation with Mark Snookal. All I had, Mark
21 Snookal, was an advisory role stemming from the
22 occupational health. Not my patient. Medical
23 consultation is different from advisory role.

24 Q. Okay. Have you ever spoken with anyone who was
25 a treating physician for Mark Snookal?

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1 A. No. The occupational health unit is not a
2 treating physician for Mark Snookal.

3 Q. Okay. Have you ever reviewed Mark Snookal's
4 employment history with Chevron or otherwise?

5 MS. FAN: Objection. Vague and ambiguous.

6 THE WITNESS: It's -- I have only the
7 cardiovascular portion of his investigation, not
8 history. Medical consultation either physical or
9 virtual is divided broadly into three major aspects:
10 History taking, physical or clinical examination, and
11 investigation.

12 Now, for me, it is that investigation aspect; I
13 only saw just the cardiac one. So I cannot claim to
14 know medical history or employment history of Mark
15 Snookal. I don't know if I'm clear.

16 BY MS. FLECHSIG:

17 Q. Yeah. I understand. Thank you. Thank you,
18 Doctor. Okay. I'm going to pull up a document. I'll
19 mark this as Exhibit A.

20 (Exhibit A marked for
21 identification.)

22 BY MS. FLECHSIG:

23 Q. It's been produced as CUSA000768 through 770.
24 And, Dr. Adeyeye, I'm going to share my screen so you
25 can see it and have an opportunity to review it.

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1 Are you able to see Exhibit A, Dr. Adeyeye?

2 A. Yes, I can see.

3 Q. Okay. I'm going to scroll to the bottom.

4 MS. FAN: And, Dr. Adeyeye, if you need to take
5 some time to review the document, I'm sure counsel would
6 be willing to scroll up and down as you need.

7 BY MS. FLECHSIG:

8 Q. Absolutely. So I'm here at the bottom of the
9 document, CUSA000770. So here, it looks like there's a
10 July 30th, 2019, e-mail from Dr. Asekomeh to Dr. Pitan
11 with a CC to NIGEC Staff Physicians. I'm going to
12 scroll up. So looks like on August 5th, 2019,
13 Dr. Asekomeh e-mailed to you, Dr. Adeyeye, with a CC to
14 Dr. Aiwuyo and Dr. Pitan.

15 Are you seeing this e-mail, Dr. Adeyeye?

16 A. Yes, I can see the e-mail.

17 Q. Okay.

18 A. I am -- I'm aware of this, but I was not aware
19 of that first one, the one from Asekomeh to Pitan.

20 Q. Okay. So this -- this e-mail you received from
21 Dr. Asekomeh here --

22 A. Yes.

23 Q. -- at the top of 770?

24 A. Yes. Yes.

25 Q. Okay. Okay. And it looks like Dr. Asekomeh's

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1 asking you to weigh in on a few things, potential
2 complications and the likelihood of progression --

3 A. Yes.

4 Q. -- management of these complications, possible
5 instructions to communicate to employee as per
6 preventing complications.

7 A. Yes.

8 Q. So this looks like a true and correct copy of
9 an e-mail you received back on August 5th, 2019?

10 A. Yes.

11 MS. FAN: Objection. Leading. Vague and
12 ambiguous.

13 BY MS. FLECHSIG:

14 Q. Is -- sorry, is that a "yes"?

15 A. That's an e-mail to me by -- from Dr. Asekomeh.

16 Q. Right. And it looks -- it looks correct; you
17 recall this e-mail?

18 A. I recall that e-mail from Dr. Asekomeh to me,
19 Dr. Adeyeye, asking me to make comments on those three
20 points.

21 Q. Okay. I'm going to continue scrolling up to
22 769 here and to 768.

23 So Dr. Aiwuyo sends this e-mail to you and
24 Dr. Asekomeh with a CC --

25 A. Yes.

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1 Q. -- to Dr. Pitan?

2 A. Yes.

3 Q. And it looks like Dr. Aiwuyo makes some
4 impressions on Mark Snookal's case.

5 A. Yes.

6 Q. I understand you said Dr. Aiwuyo is a part of
7 the occupational health department; correct?

8 A. Yes.

9 Q. Do you know -- is he also a cardiologist?

10 A. Yes.

11 Q. Okay. Does Dr. Aiwuyo still work in the
12 occupational health division, to your knowledge?

13 A. No. No.

14 Q. He no longer works there?

15 A. He's no longer working there.

16 Q. Okay. Do you know whether he still works --
17 like, does work for Chevron Nigeria?

18 A. Not at all.

19 MS. FAN: Objection.

20 BY MS. FLECHSIG:

21 Q. Okay. And I just want to give you an
22 opportunity to read through this e-mail from Dr. Aiwuyo.

23 Have you had a chance to read through the
24 e-mail?

25 A. Yes. Go on.

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1 Q. Okay. It looks like Dr. Aiwuyo linked this
2 article here.

3 Is -- are you familiar with what the article
4 says?

5 MS. FAN: Objection. Vague and ambiguous.

6 THE WITNESS: Mrs. Olivia, be more specific,
7 please, in your questioning, please.

8 BY MS. FLECHSIG:

9 Q. Sure.

10 A. Yes.

11 Q. Sure. No problem. I guess -- I guess -- you
12 know, did you read -- when you received this e-mail from
13 Dr. Aiwuyo, did you read the article that he linked?

14 A. Yes. I click on the link, and I read the
15 article from which he extracted the information. Thank
16 you.

17 Q. Okay. Understood. Did you do anything to
18 search for any other articles that might have been
19 applicable to Mark Snookal's cardiology condition --
20 cardiac condition?

21 A. You mean do I do my own literature search?

22 Q. Correct. Yeah.

23 Did you look for other articles --

24 A. Sure, yes.

25 Q. -- in response to --

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1 A. Yes.

2 Q. -- Mark Snookal --

3 A. Yes.

4 Q. Okay.

5 A. Yes.

6 Q. Okay. What did you do to look for those
7 articles?

8 A. Hello? Excuse me?

9 Q. Oh, sorry. We must have cut out for a moment.

10 What did you do to look for those articles or
11 the medical research that could pertain to Mark
12 Snookal's cardiac condition?

13 A. All I did was to look at the current update as
14 of 2019, what literature says on aortic dilatation
15 management so I can give an informed opinion, which was
16 captured in my e-mail as response to this. I'm sure
17 you'll see --

18 (Reporter clarification.)

19 THE WITNESS: I read those documents. I make
20 my own search for me to have an informed opinion based
21 on medical literature. And that was captured in my
22 e-mail response, which is -- yes.

23 BY MS. FLECHSIG:

24 Q. Okay. Let's go there next.

25 A. Yes.

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1 Q. So we're at the top of Exhibit A now.

2 A. Yes, that's my response. That's the summary of
3 my own search.

4 Q. Okay. So there's this August 5th, 2019,
5 e-mail, and this is your summary of your research;
6 correct?

7 A. Yeah. Yeah. Yes.

8 Q. Okay. There's -- is there anything that you
9 know today that would change your opinion of what you
10 expressed in that August 5th, 2019, e-mail?

11 A. I don't get your question, please. Again,
12 please. Repeat again, please.

13 Q. Oh, I'm sorry. I think my internet --
14 apologies. Yeah.

15 I just was asking is the opinion you expressed
16 in this August 5th, 2019, e-mail -- is that consistent
17 still with your opinion today of Mark Snookal's cardiac
18 condition?

19 A. Very consistent. Very consistent.

20 Q. Okay. So you said that you undertook some
21 research to inform this opinion.

22 What did you do to find -- what did you do to
23 research?

24 A. First of all, I search for such cases in
25 Nigeria, and that brought me to a publication I was part

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1 of the author; 2,501 echocardiographic studies for
2 individuals with heart conditions. I mean 2,501 cardiac
3 patients, what did we find out is their cardiac
4 condition. Why is that so? That is so, for me, to have
5 an idea how many of such cases do we see in real life.

6 And I found out that it's quite very rare.
7 This publication, which I'm part of the author, is
8 available -- can be made available to you. Out of
9 2,501, no such case, and that tells you the reality of
10 the condition, the limited cases of such condition to
11 warrant physicians' experience.

12 Then I also found out that most of those cases
13 were from autopsy, not in real life. I look at
14 literature and I saw that, oh, even for those cases
15 being found, they were found at autopsy. Those are
16 local cases. And I also look at a U.S. study between
17 1999 and 2016, then; the epidemiology of fatal ruptured
18 aortic aneurysms in the United States. Epidemiology of
19 fatal ruptured aortic aneurysms in the United States,
20 1999 to 2016.

21 This also gives me an idea how much of
22 mortality is still with this condition. So putting all
23 these things together, I was able to have my own
24 opinion; which, looking at literature from 2019 to now,
25 they say the same; and I am able to advise, as put in

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1 this, my write-up, on such cases. Thank you.

2 Q. Okay. Thank you for that. I just wanted to
3 clarify.

4 How many -- how many studies did you review?
5 It sounds like there were two. Or am I missing some?

6 A. Okay. Two local studies. I can remember one
7 now. And one foreign study. The foreign study is the
8 one in United States, 1999 to 2016, epidemiology of
9 fatal ruptured aortic aneurysms in United States, 1999
10 to 2016. The local one I remember vividly was an
11 article I also am part of the co-authors, the 2,501
12 cases echocardiographic studies done in the Southwestern
13 Nigeria. This can be made available to you if you are
14 so interested, or you can go online and search there.
15 Thank you.

16 Q. Okay. So the local study using 2,051
17 echocardiographic studies --

18 A. 2,501. '501.

19 Q. 2,501?

20 A. '01. '501, yes.

21 Q. Sorry. Okay. 2,501 local studies.

22 You said it's reviewing that number of
23 echocardiographic studies; correct?

24 A. Yes.

25 Q. But it's not specifically on people with

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1 dilated aortic roots; it's just echocardiographic
2 studies generally; correct?

3 A. Yes. That's a sample study showing us that
4 that condition is rare. If you do echo on 2,501
5 individual and cannot have one case, that tells you it's
6 quite rare. And the available local studies of such
7 cases are at postmortem, autopsy, and that gives a lot
8 of clinical information. Thank you.

9 Q. Understood.

10 (Reporter clarification.)

11 BY MS. FLECHSIG:

12 Q. The postmortem studies, is -- strike that.

13 So you said of the 2,501 echocardiographic
14 studies done locally, none of those showed patients with
15 a dilated aortic root; correct?

16 A. Correct. Correct.

17 Q. Okay. Is it fair to say that dilated aortic
18 roots are more rare in Nigeria than in the United
19 States?

20 A. You cannot say that because we've not actually
21 compare region to region. What we can say is most cases
22 are found at autopsy.

23 Q. Understood.

24 A. Because patients don't often live to warrant
25 such evaluation for treatment and what have you. I

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1 don't know if I'm getting my point. So it takes high
2 index of suspicion and a standard screening methods for
3 you to dictate. But any country where autopsy is top
4 notch, you can see more of such.

5 Q. Understood. Did any of the studies you
6 referred to refer to a patient's risk of mortality when
7 they do have a dilated aortic root?

8 A. Mortality is over 90 percent.

9 Q. So -- okay. So let me clarify.

10 You referred to -- the studies referred to
11 someone with a dilated aortic root having a 90 percent
12 risk of mortality?

13 A. Over 90 percent risk of mortality.

14 Q. Is that a risk of mortality once they have
15 suffered a dissection or rupture?

16 A. That is once they have suffered a dissection or
17 rupture.

18 Q. Okay.

19 A. The mortality --

20 Q. I am so sorry. Go ahead.

21 A. In other words, when they suffer a dissection
22 or rupture; the chance, the likelihood of that is over
23 90 percent.

24 Q. Understood. Which of the studies that you
25 cited referred to that statistic?

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1 A. Some of the local studies revealed before my
2 submission.

3 Q. Okay. Did any of the studies you referred to
4 discuss the overall risk of a rupture or dissection
5 occurring when someone has a dilated aortic root?

6 A. The risk of rupture or dissection is done based
7 on those centers, those regions that were able to pool
8 patient with aortic dilatation, and they were able to
9 put some theory to measure the risk. Like I told you,
10 in our setting, it is not a common occurrence.

11 If I are to do 2,501 echocardiography, and I
12 cannot find one, so how many will I do to have a sizable
13 number to apportion risk? I don't know if I'm clear on
14 that.

15 Q. Yeah, I think so. What I'm trying to
16 understand is, I guess, did you refer to anything that
17 gave you a sense of how often someone with a dilated
18 aortic root has a rupture or a dissection?

19 A. Yes. Yes. Some of them in that e-mail link,
20 if you click on them and read, you will see the Western
21 literatures studying the risk of dissection, the risk of
22 rupture, and the attendant mortality related.

23 Q. In the -- you're referring to the University of
24 Calgary article that Dr. Aiwuyo linked to?

25 A. Those links.

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1 did he have symptoms?" I hope I've been able to clear
2 that. Thank you.

3 Q. Okay. So is it fair to say, then, given the
4 knowledge you had at the time, you did not know whether
5 or not Mr. Snookal was having symptoms of an aneurysm?

6 A. Excellent.

7 Q. Okay. What are symptoms of an aortic aneurysm,
8 if you know?

9 A. Generally speaking, symptoms of aortic aneurysm
10 includes chest pain, difficulty with breathing,
11 occasionally some fainting spell. Other additional
12 symptoms, if it's progressive, include, like, nausea,
13 vomiting, and signs or symptoms of systemic shock when
14 the ruptures occur. These are things that are
15 time-bound from the patient.

16 Q. Understood. When you reviewed the literature
17 to evaluate Mr. Snookal's risk of a dissection or
18 rupture occurring, did you refer to any studies that
19 discuss the relative -- the risk relative to the size of
20 the dilation?

21 A. Yes.

22 Q. And that's the University of Calgary study that
23 Dr. Aiwuyo cited?

24 A. Yes.

25 Q. Okay. Any other studies that you were able to

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1 find that would evaluate that specific risk of a serious
2 cardiac event occurring?

3 A. Fortunately or unfortunately, such rare
4 conditions fall into what we'll call guideline-directed
5 therapy or management, in which case we have a unified
6 guideline for such cases. And these guidelines are
7 pulled out of multiple experiences, multiple cases have
8 been seen, and they be able to come up with one
9 guideline. I mean the whole Canada, the whole U.S.
10 could have one guideline made by the expats for such
11 cases. So that becomes applicable.

12 In Nigeria where I practice, of course, we are
13 limited by such cases -- such cases, so I cannot say,
14 oh, I will look at that guideline of the risk associated
15 with such dimension of ease. Thank you.

16 Q. Understood. Thank you, Doctor. Okay. I want
17 to show you Exhibit B. So in Exhibit A, it -- you know,
18 Dr. Asekomeh, it sounds like, attaches a medical report
19 and a cardiologist report from April 2019. Exhibit B --
20 here, let me share my screen first.

21 (Exhibit B marked for
22 identification.)

23 BY MS. FLECHSIG:

24 Q. Exhibit B has been produced as CUSA000775.

25 Are you able to see my screen, Mr. -- excuse

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1 me, Dr. Adeyeye?

2 A. I can see your screen. I can see it.

3 Q. Okay. Is this the medical report that -- that
4 Dr. Asekomeh sent you attached to the e-mail we reviewed
5 earlier today?

6 A. No, no, no, no. This is a classified
7 information for only the occupational health team, not
8 for any cardiologist for their opinion. What
9 cardiologist only look for is the ECG, echocardiogram,
10 plus or minus computed tomographic angiography, not all
11 these details of liver function, kidney functions,
12 QuantiFERON, and all that. We are not privy to all
13 this.

14 This is their own field. It is a submission of
15 what they get from specialists that inform them writing
16 this. And that's why I answer you earlier, I'm not
17 privy to his full history. And I've given you the three
18 buckets of medical consultation. Thank you.

19 Q. Understood. So you did not have an
20 opportunity --

21 A. Huh-uh, huh-uh.

22 Q. -- to review this before making an evaluation
23 of Mr. Snookal's cardiac condition.

24 A. At all. At all. At all.

25 MS. FAN: Objection. Argumentative.

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1 THE WITNESS: I do not need the full story, as
2 written here, to offer cardiologist opinion. I do not
3 need patient history, I do not need patient liver
4 function or renal function, as captured in that report,
5 to offer my cardiologist opinion. Because if you look
6 at the guideline, the guideline are so specific, and
7 they are made based on the case at hand, not based on
8 the exposure to tuberculosis, full blood count,
9 genotype, urine result, no.

10 They are made based on an individual with an
11 ECG like this, an individual with an echo report like
12 this, and a individual with a CTA like this, as a
13 cardiologist, what is our opinion, what is our stand,
14 and we give it as such. Regardless of all that, of a
15 previous cholecystectomy, of a previous tooth
16 extraction, of a previous ear piercing, those are not
17 issues for us to make our own informed decision. And
18 that is the practice in cardiology.

19 BY MS. FLECHSIG:

20 Q. Understood. Thank you, Doctor. So let me show
21 you what I'm marking as Exhibit C.

22 (Exhibit C marked for
23 identification.)

24 BY MS. FLECHSIG:

25 Q. This has been produced as CUSA000818 through

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1 822.

2 Dr. Adeyeye, I believe this is -- this is a
3 cardiology report on Mark Snookal; correct?

4 MS. FAN: Objection. Calls for speculation.

5 THE WITNESS: How do I know the qualification
6 of the person? How do I know the person and the
7 qualification? What I just see -- oh, attending
8 cardiology, S Khan, M.D. That's the name.

9 BY MS. FLECHSIG:

10 Q. Yeah. I understand. I guess what I'm asking
11 is just -- is this the cardiology report on Mark Snookal
12 that you reviewed back in 2019?

13 A. No. No. No. No. A cardiologist opinion is a
14 blinded opinion. Please note, a cardiologist opinion is
15 a blinded opinion, meaning that you're not privy to what
16 A is saying, you're not privy to what B is saying,
17 you're not privy to what C is saying, you are to make
18 your own opinion.

19 And for these two, three opinion, an informed
20 decision could be made. I'm not supposed and I don't
21 look at or they don't give this to make an opinion. So
22 for me, I wasn't privy to this document as of that time.
23 What I only made my opinion based on is ECG, like I said
24 before, echocardiograph, like I said before, and a CTA,
25 computer tomographic angiography.

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1 Those are the things I needed to make an
2 informed opinion, not all these report by somebody else
3 who made his own opinion, probably after medical
4 consultation. You can only write like this after
5 medical consultation, not when you are seeking your
6 advisory role. I hope that is clear.

7 Q. Understood. So you did not feel it was
8 relevant to review Mr. Snookal's treating cardiologist's
9 impressions of his cardiac conditions?

10 MS. FAN: Objection. Argumentative. Vague and
11 ambiguous.

12 THE WITNESS: I don't need to know what
13 Mr. Snookal's attending cardiologist write before I make
14 my own opinion. Same way any other cardiologist in any
15 part of the world tells me that a patient has congenital
16 cardiac failure with ejection fraction of 30 to 40
17 percent, Dr. Adeyeye, what is the chance of this person
18 dying within one year -- six months to one year? I can
19 give you my value without even knowing the name or the
20 gender of that person.

21 That is the way cardiologists go about work.
22 It is data, evidence-based, not all of this, what was
23 the height, what was the weight, what's the BMI, does he
24 smoke, does he take alcohol -- no. These are facts that
25 I've been saying. Patient with heart failure, ejection

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1 fraction 40 percent, are likely to die --

2 (Reporter clarification.)

3 THE WITNESS: -- 50 percent of them --

4 (Reporter clarification.)

5 THE WITNESS: -- within six months to one
6 year.

7 (Reporter admonishment.)

8 BY MS. FLECHSIG:

9 Q. Okay. The -- I understand you said you
10 reviewed three scans of Mr. Snookal's hearts -- of his
11 heart. Excuse me.

12 Of those scans, were they all from 2019.

13 A. Yes. That's why this comes -- he presented to
14 them for screening or what have you -- for
15 pre-employment screening. It's ECG, echo, and CTA.

16 Q. Okay. Understood. And you were not able to
17 view whether the results of those scans changed or were
18 stable over time for Mr. Snookal?

19 A. I said it over and over. Medical consultation
20 is different -- totally different from medical advisory
21 role. Looking at those things, whether they've changed,
22 whether they were there or not, requires medical
23 consultation of me with Mr. Snookal, not somebody asking
24 me for advisory role on Mr. Snookal. Those are two
25 different things.

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1 Please, let's tease this out so that this
2 question can be more specific and the answer to be more
3 specific. We are bringing in too many things on the
4 table now. Please.

5 Q. Yeah. I think I understand, Doctor. I guess,
6 just, what I'm asking is: You only viewed one set of
7 his scans from one point in time; correct?

8 A. I was given his cardiac investigation results
9 and to make an advisory statement on that cardiac
10 investigation results. Thank you.

11 Q. And the cardiac investigation results were not
12 based off of scans over time of Mark Snookal; correct?

13 A. They were based on what he presented to them at
14 the occupational health unit.

15 Q. Okay. So did the occupational health unit
16 share with you Mark Snookal's scans over time?

17 A. No. I was only privy to what he presented to
18 them that they seek my opinion on. That's all.

19 Q. Understood. Okay. Did you -- so other than
20 the e-mail that we reviewed together, did you discuss
21 Mr. Snookal's cardiac condition in any other
22 communications, whether that's orally, in real time,
23 over the phone, anything like that?

24 A. All we did was exchange of e-mail, so from me
25 to the team in occupational health, and the e-mail train

Dr. Victor Adeyeye

April 22, 2025

CERTIFICATE OF STENOGRAPHIC REPORTER

I, RACHEL N. BARKUME, a Certified Shorthand
Reporter of the State of California, hereby certify that
the witness in the foregoing deposition,

DR. VICTOR ADEYEYE,
was by me duly sworn to tell the truth, the whole truth,
and nothing but the truth in the within-entitled cause;
that said deposition was taken at the time and place
therein named; that the testimony of said witness was
stenographically reported by me, a disinterested person,
and was thereafter transcribed into typewriting.

Pursuant to Federal Rule 30(e), transcript
review was requested.

I further certify that I am not of counsel or
attorney for either or any of the parties to said
deposition, nor in any way interested in the outcome of
the cause named in said caption.

DATED: May 6, 2025.

Rachel N. Barkume

Rachel N. Barkume, CSR No. 13657, RMR, CRR

From: ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>

Sent: Monday, 5 August 2019 17:55

To: Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>; Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>

Cc: Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>

Subject: RE: Snookal, Mark- Medical report

Sir/Ma,

I agree with Dr Aiwuyo submissions on above employee, especially the precautionary measures highlighted which we need to further reiterate to our client.

I have a little concern about his choice of anti-hypertensives (Losartan and Amlodipine). Guideline-directed management recommends Beta-blockers like Carvedilol, Bisoprolol as part of his blood pressure control meds with a systolic BP target of less than 120mmHg (Thoracic aortic aneurysm and documented runs of premature ventricular complexes).

It will be nice if this is brought to the attention of his physician.

Kind regards,

Victor.

From: Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>

Sent: Monday, August 5, 2019 2:26 PM

To: Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>; ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>

Cc: Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>

Subject: RE: Snookal, Mark- Medical report

Good day,

With regards to this expert, 47years old employee with CT and ultrasound evidence of Thoracic aortic aneurysm,

It was documented in the report that he has aortic dilatation of 4.4cm on ECHCARDIOGRAPHY,

however CT aortography which is a more accurate imaging modality revealed a maximum value of 4.2cm max at the aortic root and 4.1cm max at the descending thoracic aorta.

From the Canadian guidelines these values appear low risk for a major adverse CV event. Some have used values of <4.5cm as partition value for low risk situations., link below refers.

<https://www.ucalgary.ca/FTWguidelines/content/aortic-aneurysm>

it is expected that every aneurysm must be subjected to 6months- 1year assessment to ascertain the rate of progression (>1cm is an indication for repair). I feel there should be a concrete plan by his home cardiologist for this

evaluation.

Below are my response to the questions put forward:

1. Complications associated with aneurysms include

- a. Rupture/dissection (sudden and catastrophic) and its attendant sequela
- b. Thromboembolic phenomenon
- c. Pressure symptoms on other vital organs
- d. Sudden death

2. In Escravos unfortunately we are only limited to initial stabilization and transfer of such high risk CV complications if any occurs. In the unlikely event of any of the aforementioned complications, we may not be able to support such an individual due to our peculiarities.

3. Instructions for the patient

- avoid lifting heavy objects
- quit smoking (if he is a smoker)
- manage hypertension strictly, there is need to aim for lower targets <120mmhg systolic (DOC beta blockers)
- watch out for alarm symptoms like pain in the chest (throbbing, tearing, aching or sharp pain, often sudden), pain in the back, nausea, vomiting, fainting, and systemic shock
- avoid moderate to high intensity exercises as much as possible

I made effort to search the MEP if there are clear cut field guidelines for patient with aortic aneurysm, unfortunately I found none. What is established is that a patient with symptomatic aneurysm should not be allowed to work in an offshore location.

I am still open to further discussions on this sir.

Warm regards.

DR. AIWUYO, HENRY

OH Physician/Cardiologist

EGTL clinic

EXT-77943

B2B dr oyebowale olaniyi

"as to diseases, make a habit of two things- to help, or at least, to do no harm"
hippocrates

From: Asekomeh, Eshiofe [DELOG] <EAEV@chevron.com>
Sent: Monday, August 5, 2019 11:43 AM
To: ADEYEYE, VICTOR [DELOG MEDICAL SERVICES] <DNOY@chevron.com>
Cc: Aiwuyo, Henry [SERVITICO] <henryaiwuyo@chevron.com>; Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
Subject: FW: Snookal, Mark- Medical report

Good day,

Below mail trail refers. Kindly help evaluated medical documents and attached Cardiologist report for above named EE who is coming to Escravos from the USA. His job description is- Reliability Engineering Manager.

Kindly review around the following key points:

1. Potential complications and the likelihood of progression
2. Management of these complications even if only initial intervention vis-à-vis available care level in Escravos
3. Possible instructions to communicate to employee as per preventing complications.

Thanks for your usual help.

Warm regards,

Eshiofe Asekomeh

From: Asekomeh, Eshiofe [DELOG]
Sent: Tuesday, July 30, 2019 7:44 PM
To: Pitan, Olorunfemi (femi.pitan) <femi.pitan@chevron.com>
Cc: NIGEC Staff Physicians (l9esc300) <L9ESC300@chevron.com>
Subject: Snookal, Mark- Medical report

Good day Ma,

I will like to discuss Mark Snookal (Manager, Reliability Engineering) with you tomorrow. He is on transfer from El Segundo, USA to Escravos, Nigeria on international assignment.

He has aortic root dilatation and was reviewed by a Cardiologist April this year. The examining Physician in the US had declared him fit with limitation (not to lift weight above 50 pounds)

Attached are the medical reports and the Cardiologist report from April, 2019.

Warm regards,

Eshiofe Asekomeh

Dr. Asekomeh E.G
Chevron Hospital
Warri, Nigeria

MEDICAL SUMMARY

RE: SNOOKAL MARK DOB- [REDACTED]

Above named 47-year old employee is on international transfer from El Segundo, USA to Escravos, Nigeria for international assignment as a Reliability Engineering Manager. He had his medical Suitability for Expatriate Assignment (MSEA) evaluation on the 24th of July 2019.

Significant/ relevant medical history gleaned from his GO-146 include;

-History of being hypertensive and presently on Lorsatan and amlodipine- date of diagnosis/ date of commencement and dosages not stated.

- He exercises regularly for at least thirty minutes at three times a week on average

- He is a non-smoker

- A past medical history of treatment for depression between 1994 and 1996

- He had a cholecystectomy in 2014

- A significant history of diagnosis of asymptomatic dilated aortic root and premature ventricular complexes on ECG for which the Cardiologist recommended no additional treatment.

Main findings on examination was a bradycardia with pulse rate of 53/min and blood pressure of 135/78mmHg.

Review of recent investigations revealed:

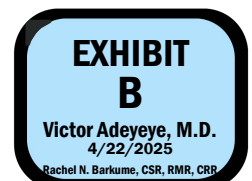
1. ECG: Heart rate of 47/min, sinus rhythm with PVC, left atrial deviation and slight intraventricular delay
2. Slightly borderline elevated triglyceride and LDL cholesterol and reduced HDL cholesterol
3. Normal E/U/Cr, LFT, CBC and urine analysis
4. Negative Quantiferon TB test

Transthoracic echocardiography done on 9th of April 2019 revealed aortic root diameter of 4.4 cm with normal aortic arch size.

CT Angiography done on the 10th of April 2019 also reported a stable aortic arch (Compared to an earlier CT angiography done on 10th of May 2017) with a diameter of 4.2cm and a maximum size of the ascending aorta of 4.1cm.

Dr. Asekomeh E.G

7/08/2019



CUSA000775

EXHIBIT 2/30 B.1

CAI - MVZM Name: Shookal, Mark Sex: M
 GUID - 1000444873 ID #: 8155
 US - MVZM
 MANUFACTURING - MVZM

Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019 Continued...
 Author: 0000 Location:
 Revised by: White, Ghada S Create Date: 07-29-2019 03:56pm
 Type: Progress Note
 Subject: Cardiology Report

KAISER PERMANENTE

RECEIVED

JUL 29 2019

LOS ANGELES MEDICAL
 CNTR L
 4867 W. SUNSET BLVD.
 LOS ANGELES CA 90027-
 5969

Shookal, Mark J
 MRN: 000004554567, DOB: 4/13/1972, Sex: M
 Visit date: 4/3/2019

Order Providers		
Authorizing Khan, Shahid Hameed (M.D.)	Encounter Khan, Shahid Hameed (M.D.)	Billing Khan, Shahid Hameed (M.D.)

Order Information		
Date 4/3/2019	Department CARDIOLOGY	Ordering/Authorizing Khan, Shahid Hameed (M.D.), M.D.

Associated Diagnoses
 AORTIC ANEURYSM
 AORTIC VALVE REGURGITATION

Result Information	
Status: Final result (Collected: 4/10/2019 08:57)	Provider Status: Reviewed

Result Notes for CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM

Notes recorded by Khan, Shahid Hameed (M.D.), M.D. on 4/11/2019 at 11:35 AM PDT
 Call Center Nurses: Please let patient know that his Aorta looks stable on his recent CT scan. No change in aortic size.

CTA Aorta 4/10/2019:
 Aortic root is stable at 4.2 cm. Maximal size of ascending thoracic aorta is 4.1 cm. Compared to 5/16/17 there has been no significant Change

Electronically signed by,

S. KHAN MD
 Attending Cardiologist, Division of Cardiology, SCPMG
 Clinical Associate Professor, UCLA School of Medicine
 Ph: 323-783-4585
 4/11/2019
 11:35 AM

4/10/2019 10:28 AM - Interface, Scal_Radiology

Narrative
 CT1/4 8e" PREFER MON/WED PROTOCOL: GATED AORTA.

Lab and Collection
 CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM - 4/3/2019

Result History
 CTA CARDIAC W CONTRAST, WO QUANTITATIVE CALCIUM on 4/10/2019

Transcription

Type	ID	Date and Time	Dictating Provider
Diagnostic imaging	86769685	4/10/2019 10:28 AM	Hsu, Joe Yo (M.D.), M.D.
Signed by Hsu, Joe Yo (M.D.), MEDICAL DOCTOR on 04/10/19 at 1028			

CARDIAC CTA: 4/10/19

Kaiser Permanente

Page 1



CUSA000818

EXHIBIT 2/31

CAI - MVZM

Name: Snookal, Mark Sex: M

GUID - 1000444873

DOB: 04-13-1972 Age: 47

US - MVZM

MANUFACTURING - MVZM

Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019

...Continued...

Author: 0000

Location:

Revised by: White, Ghada S Create Date: 07-29-2019 03:56pm

Type: Progress Note

Subject: Cardiology Report

KAISER PERMANENTELOS ANGELES MEDICAL
CNTR L
4867 W. SUNSET BLVD.
LOS ANGELES CA 90027-
5969

Snookal, Mark J

MRN: 000004554567, DOB: 4/13/1972, Sex: M

Visit date: 4/3/2019

HISTORY: 46-year-old male with aortic regurgitation and aortic root enlargement.

TECHNIQUE: Cardiac CTA is performed following administration of 130 ml of IV contrast material.

As required by California law, the CTDIvol and DLP radiation doses associated with this CT study are listed below. This represents the estimated dose to a standard lucite phantom resulting from the technique used for this study, but is not the dose to this specific patient.

Type / CTDIvol / DLP / Phantom

Chest / 5.55 / 136.04 / B

Chest / 16.46 / 8.23 / B

Chest / 17.39 / 365.11 / B

Total Exam DLP: 509.38

CTDIvol = mGy DLP = mGy-cm

Phantom: B=Body32, H=Head16

QUALITY: Fair, arrhythmia with PVCs

COMPARISONS: CTA 5/126/17, 5/26/16, 4/21/15

FINDINGS:

AORTA: Left arch with normal branching of great vessels. Normal ductus bump.

AORTIC VALVE: 3 cusps without calcification.

Aortic measurements are as follows:

AORTIC ANNULUS: 2.1 x 3.5 cm

AORTIC ROOT: 4.2 cm (average of 3 measurements from convexity to commissure)

SINO-TUBULAR JUNCTION: 3.7 x 3.8 cm

ASCENDING AORTA AT LEVEL OF RIGHT PULMONARY ARTERY: 3.9 x 4.1 cm

AORTIC ARCH: 2.7 x 3.0 cm (proximal to origin of left subclavian artery)

DESCENDING AORTA AT LEVEL OF RIGHT PULMONARY ARTERY: 2.7 x 2.9 cm

ABDOMINAL AORTA AT HIATUS: 2.5 x 2.6 cm

OTHER FINDINGS: Lungs are clear. No acute airspace disease. No

Kaiser Permanente

Page 2

CUSA000819

EXHIBIT 2/32 C.2

CAI - MVZM

Name: Shookal, Mark Sex: M

GUID - 1000444873

DOB: 04-13-1972 Age: 47

US - MVZM

MANUFACTURING - MVZM

Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019

...Continued...

Author: 0000

Location:

Revised by: White, Ghada S Create Date: 07-29-2019 03:56pm

Type: Progress Note

Subject: Cardiology Report

KAISER PERMANENTELOS ANGELES MEDICAL
CNTR L
4867 W. SUNSET BLVD.
LOS ANGELES CA 90027-
5969Shookal, Mark J
MRN: 000004554567, DOB: 4/13/1972, Sex: M
Visit date: 4/3/2019

effusion or consolidation seen. No mediastinal or hilar
lymphadenopathy. Visualized upper abdomen show cholecystectomy.

IMPRESSION:

Aortic root is stable at 4.2 cm. Maximal size of ascending thoracic
aorta is 4.1 cm.

Compared to 5/16/17 there has been no significant change.

This report electronically signed by Joe Hsu, MD on 4/10/2019 10:23 A

Display only: Transcription (86769685) on 4/10/2019 10:28 AM by Hsu, Joe Yo (M.D.), M.D.

Order Providers

Authorizing	Encounter	Billing
Khan, Shahid Hameed (M.D.)	Lockerbie, Colin S	SCAL PROVIDER

Order Information

Date	Department	Released By	Authorizing
4/9/2019	CARDIOLOGY	Lockerbie, Colin S	Khan, Shahid Hameed (M.D.), M.D.

Original Order

Ordered On	Ordered By
4/9/2019 3:25 PM	Lockerbie, Colin S

Associated Diagnoses**AORTIC VALVE REGURGITATION****Result Information**

Status: Final result (Collected: 4/9/2019 15:32)	Provider Status: Reviewed

4/16/2019 2:02 PM - Interface, Scal_Results_A

Component
REPORT

CAI - MVZM
 GUID - 1000444873
 US - MVZM
 MANUFACTURING - MVZM

Name: Snookal, Mark Sex: M
 ID #: 8158
 DOB: 04-13-1972 Age: 47

Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019 ...Continued...
 Author: 0000 Location:
 Revised by: White, Ghada S Create Date: 07-29-2019 03:56pm
 Type: Progress Note
 Subject: Cardiology Report

KAISER PERMANENTE

LOS ANGELES MEDICAL
 CNTR L
 4867 W. SUNSET BLVD.
 LOS ANGELES CA 90027-
 5969

Snookal, Mark J
 MRN: 000004554567, DOB: 4/13/1972, Sex: M
 Visit date: 4/9/2019

4/16/2019 2:02 PM - Interface, Scal Results_A (continued)

Conclusions

Summary

Technically very difficult study.
 NSR with frequent PVCs.

Normal left ventricular wall thickness. Mildly increased left ventricular size and normal systolic function with an estimated ejection fraction of 55-60%. Indeterminate diastolic function.
 Upper normal left atrial size. Mild right atrial enlargement.
 Upper normal right ventricular size and systolic function.

Structurally normal mitral valve without stenosis. Trace mitral regurgitation.
 Structurally normal trileaflet aortic valve. Mild to moderate eccentric aortic regurgitation. No aortic stenosis. Aortic regurgitant pressure half-time is 524 ms.
 Aortic root measures 4.4 cm. Normal aortic arch size.

Findings

Mitral Valve

Structurally normal mitral valve without stenosis. Trace mitral regurgitation.

Aortic Valve

Structurally normal trileaflet aortic valve. Mild to moderate eccentric aortic regurgitation. No aortic stenosis. Aortic regurgitant pressure half-time is 524 ms.

Tricuspid Valve

Cannot reliably estimate right ventricular systolic pressure (RVSP).

Pulmonic Valve

The pulmonic valve leaflets are thin and pliable; valve motion is normal. Mild pulmonic regurgitation is present.

Left Atrium

Upper normal left atrial size.

Left Ventricle

Normal left ventricular wall thickness. Mildly increased left ventricular size and normal systolic function with an estimated ejection fraction of 55-60%. Indeterminate diastolic function.

Right Atrium

Mild right atrial enlargement.

Right Ventricle

Upper normal right ventricular size and systolic function.

Pericardial Effusion

No pericardial effusion.

Aorta

Aortic root measures 4.4 cm. Normal aortic arch size.

Miscellaneous

IVC diameter is = 2.1 cm with a > 50% inspiratory collapse, suggestive of a right atrial pressure of 0-5 mmHg.

Signature

Electronically signed by LEBOWITZ, STEPHEN HOWARD MD (Interpreting physician) on 04/16/2019 02:01 PM

** Note: For images and the full report use the "PACS Images" link below **

CAI - MVZM
GUID - 1000444873
US - MVZM
MANUFACTURING - MVZM

Name: Shookal, Mark Sex: M
DOB: 04-13-1972 Age: 47

Doc ID: 4913728 Revision # 0 D.O.S: 04-03-2019
Author: 0000 Location:
Revised by: White, Ghada S Create Date: 07-29-2019 03:56pm
Type: Progress Note
Subject: Cardiology Report

...Continued

KAISER PERMANENTE

LOS ANGELES MEDICAL
CNTR L
4867 W. SUNSET BLVD.
LOS ANGELES CA 90027-
5969

Shookal, Mark J
MRN: 000004554567, DOB: 4/13/1972, Sex: M
Visit date: 4/9/2019

4/16/2019 2:02 PM - Interface, Scal_Results_A (continued)

Linked Documents

[View Image](#)

Lab and Collection

TRANSTHORACIC ECHO REAL TIME W 2D IMAGE, SPECTRAL AND COLOR FLOW DOPPLER COMPLETE -
4/9/2019

Result History

TRANSTHORACIC ECHO REAL TIME W 2D IMAGE, SPECTRAL AND COLOR FLOW DOPPLER
COMPLETE on 4/16/2019

END OF REPORT